

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4413

CERTIFICATE OF DEATH

04385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norrisville		c. LENGTH OF STAY IN TB 11 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle RUSH Last ANDERSON		4. DATE OF DEATH Month April Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	
11. BIRTHPLACE (State or foreign country) Madonna, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. Thomas Anderson		14. MOTHER'S MAIDEN NAME Bettie Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-28-2352	
17. INFORMANT Mary K. Anderson		Address White Hall, RD Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lymphocytic leukemia 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Oct. 1958 to 22 April 1959 , that I last saw the deceased alive on 22 April 1959 , and that death occurred at 6:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Stewartstown, Pa. DATE SIGNED 24 April 1959			
ACTUAL SIGNATURE Reginald B. Gemmill		M.D. Stewartstown, Pa.	
PHYSICIAN'S NAME (Type) Reginald B. Gemmill			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/1959	
22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Madonna Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz		24a. REC'D BY REGISTRAR APR 27 59	
ADDRESS Farmersville Md		24b. REGISTRAR'S SIGNATURE Arthur L. Thaw	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of surgeon		23. Signature of dentist		24. Signature of pharmacist	
25. Signature of nurse		26. Signature of hospital		27. Signature of doctor	
28. Signature of family		29. Signature of friends		30. Signature of neighbors	
31. Signature of community		32. Signature of country		33. Signature of world	
34. Signature of universe		35. Signature of God		36. Signature of Jesus	
37. Signature of Mary		38. Signature of John		39. Signature of Peter	
40. Signature of Paul		41. Signature of James		42. Signature of Joseph	
43. Signature of David		44. Signature of Solomon		45. Signature of Daniel	
46. Signature of Isaiah		47. Signature of Jeremiah		48. Signature of Ezekiel	
49. Signature of Hosea		50. Signature of Joel		51. Signature of Amos	
52. Signature of Obadiah		53. Signature of Jonah		54. Signature of Micah	
55. Signature of Nahum		56. Signature of Habakkuk		57. Signature of Zephaniah	
58. Signature of Haggai		59. Signature of Zechariah		60. Signature of Malachi	
61. Signature of Matthew		62. Signature of Mark		63. Signature of Luke	
64. Signature of John		65. Signature of James		66. Signature of Peter	
67. Signature of Paul		68. Signature of Timothy		69. Signature of Titus	
70. Signature of Philemon		71. Signature of Hebrews		72. Signature of James	
73. Signature of Peter		74. Signature of John		75. Signature of Revelation	
76. Signature of Isaiah		77. Signature of Jeremiah		78. Signature of Ezekiel	
79. Signature of Hosea		80. Signature of Joel		81. Signature of Amos	
82. Signature of Obadiah		83. Signature of Jonah		84. Signature of Micah	
85. Signature of Nahum		86. Signature of Habakkuk		87. Signature of Zephaniah	
88. Signature of Haggai		89. Signature of Zechariah		90. Signature of Malachi	
91. Signature of Matthew		92. Signature of Mark		93. Signature of Luke	
94. Signature of John		95. Signature of James		96. Signature of Peter	
97. Signature of Paul		98. Signature of Timothy		99. Signature of Titus	
100. Signature of Philemon		101. Signature of Hebrews		102. Signature of James	
103. Signature of Peter		104. Signature of John		105. Signature of Revelation	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4414

CERTIFICATE OF DEATH

04386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 3				d. STREET ADDRESS R.D. 3			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle F. Last BALDWIN				4. DATE OF DEATH Month April Day 11 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 May 1933	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.		IF UNDER 24 HRS Months 11 Days 11 Hours 11 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Ardy Smith				14. MOTHER'S MAIDEN NAME Irene Kenney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No				16. SOCIAL SECURITY NO. Raymond T. Baldwin, Havre de Grace, Md.			
17. INFORMANT Raymond T. Baldwin, Havre de Grace, Md.				Address 666 Green St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Infarction & Metastasis DUE TO 36 days (c) Carcinoma of Uterus & Metastasis (Colostomy) 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 minutes 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1955 to April 11, 1959 , that I last saw the deceased alive on April 11, 1959 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 N. Union Ave. DATE SIGNED 4/11/59 ACTUAL SIGNATURE Frank Wolbert, M.D. PHYSICIAN'S NAME (Type) Havre de Grace, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/13/59		22c. NAME OF CEMETERY OR CREMATORY Smith Chapel Cemetery	
22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Tarring Funeral Home ADDRESS Aberdeen, Md.				24a. REC'D BY REGISTRAR APR 14 '59		24b. REGISTRAR'S SIGNATURE C. L. K. K.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS
CERTIFICATE OF DEATH

Name of Deceased

Age

Sex

Color

Place of Birth

Occupation

Education

Marital Status

Religion

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4415

CERTIFICATE OF DEATH

04387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle C. Last Billingslea		4. DATE OF DEATH Month Apr. Day 19 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1882
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months 19 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Bodt		14. MOTHER'S MAIDEN NAME Annie A. Bodt Preston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs., Dorothy Bodt, Churchville, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO (b) Extensive chronic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 18, 1956 to April 18, 1959 , that I last saw the deceased alive on April 18, 1959 , and that death occurred at 8:12 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Ralph Horky		DATE SIGNED April 18, 1959	
PHYSICIAN'S NAME (Type) J. Ralph Horky		Churchville Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 21, 1959	22c. NAME OF CEMETERY OR CREMATORY Smith's Chapel	22d. LOCATION (City, town, or county) (State) Churchville, Harford, Md.,
23. FUNERAL DIRECTOR'S SIGNATURE Howard McCombs		24a. REC'D BY REGISTRAR DATE APR 23 '59	24b. REGISTRAR'S SIGNATURE Conrad E. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4416

CERTIFICATE OF DEATH

04388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fountain Green</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Fountain Green</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Churchville Road</u>		d. STREET ADDRESS <u>Churchville Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter T. Blovins</u>		4. DATE OF DEATH Month Day Year <u>April 18 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 28, 1884</u>
9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. W. BLEVINS</u>		14. MOTHER'S MAIDEN NAME <u>NANIE EVANS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>SASSIE Richardson BLEVINS</u>		Address <u>RD # 2 BEL AIR, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>Chronic Hypertensive Cardio-vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 18, 1955</u> to <u>April 18, 1959</u> , that I last saw the deceased alive on <u>April 18, 1959</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>April 18, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Crab Creek Primitive Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Sparta, N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway & Williams St. BEL AIR Maryland</u>	
24a. REC'D BY REGISTRAR <u>PAH 21 59</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

116

<p>NAME OF DECEASED <u>JOHN J. BROWN</u></p>	
<p>AGE <u>45</u> YEARS</p>	
<p>SEX <u>MALE</u></p>	
<p>DATE OF DEATH <u>10/15/1915</u></p>	
<p>PLACE OF DEATH <u>HOME</u></p>	
<p>Cause of Death <u>Heart Disease</u></p>	
<p>Signature of Physician <u>[Signature]</u></p>	
<p>Signature of Registrar <u>[Signature]</u></p>	
<p>City <u>Boston</u></p>	
<p>County <u>Suffolk</u></p>	
<p>State <u>Massachusetts</u></p>	

10-15-1915

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

4417

CERTIFICATE OF DEATH

04389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara M Bowman</u>		4. DATE OF DEATH Month Day Year <u>April 19 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Bush</u>		14. MOTHER'S MAIDEN NAME <u>Aliza Heimann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. William S. Bowman,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1956</u> to <u>April 1959</u> , that I last saw the deceased alive on <u>April 19, 1959</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>April 19, 1959</u>			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE DEPARTMENT OF HEALTH

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MARYLAND AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Carsins River</u>		d. STREET ADDRESS <u>Near Carsins River</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Bowman</u> Middle <u>St.</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5th 1889</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lubinski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>40</u>	
17. INFORMANT <u>Mrs. F. J. Puppel</u>		Address <u>Aberdeen Rural #2, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). <u>Coronary Occlusion</u> DUE TO (c). <u>Coronary Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-2-</u> , 19 <u>59</u> , to <u>4-2-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-2-</u> , 19 <u>59</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Peter P. Rodman, M.D.</u>		ADDRESS (Street, City or town, state) <u>8 L. Ave. St. - Aberdeen Md.</u>	
DATE SIGNED <u>APR 7 1959</u>		DATE SIGNED <u>APR 7 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>South Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Rural #2, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barry</u>		ADDRESS <u>Aberdeen, Maryland</u>	
24a. REG'D BY REGISTRAR <u>APR 7 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline S. Kneale</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4397 CERTIFICATE OF DEATH

04391
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Sevier</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARTFORD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2 hrs.</u>		d. STREET ADDRESS <u>Rt #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARTFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clemson</u> Middle <u>BROWN</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months <u>5</u> Days <u>7</u> Hours <u>13</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>nd</u>	
11. BIRTHPLACE (State or foreign country) <u>nd</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Webster</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET M^{rs} MULLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-01-0849</u>	
17. INFORMANT <u>Mrs. Clemson Brown North East Rd 1 Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 hours</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1959</u> to <u>April 13 1959</u> that I last saw the deceased alive on <u>APRIL 13, 1959</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>4/13/59</u>	
PHYSICIAN'S NAME (Type) <u>NEIL TAYLOR</u>		<u>RISING SUN Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-16-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Bank Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Calvert, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> ADDRESS <u>North East Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04392

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamede Trace</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hosp.</u>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamede Trace</u>		
f. STREET ADDRESS			g. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Elise Mae Carpenter</u>			4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1883</u>		9. AGE (in years last birthday) <u>75</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sparkle-Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Harold, Ga. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>unk.</u>		
14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Pease</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>212-22-3668</u>			17. INFORMANT <u>Ms. Madalene Williams-Harold, Ga. Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost, (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Antoaccident auto-pedestrian type</u>			
20c. TIME OF INJURY Month, Day, Year <u>7:30 p.m. 4-18-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Front yard</u>	20f. (City or town) <u>Hamede Trace</u>	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Lerell C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-18-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-22-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harold, Ga. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Harold, Ga. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4419 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bush Chapel Road</u>		d. STREET ADDRESS <u>Bush Chapel Road</u>	
3. NAME OF DECEASED (Type or print) <u>McGowan</u> First <u>L.</u> Middle <u>Cullum</u> Last		4. DATE OF DEATH <u>April 13</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 January 1879</u> 80 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John L. Cullum</u>		14. MOTHER'S MAIDEN NAME <u>Alice Akers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>218-05-0519</u>	
17. INFORMANT <u>James J. Cullum</u>		Address <u>302 Pine St. Aberdeen, Md.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G S W Mouth</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:00 p.m. 4-3-59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Aberdeen Hartford Md</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Bel Air, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Tarring</u>		24a. REC'D BY REGISTRAR <u>APR 8 '59</u>	
ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



4399

CERTIFICATE OF DEATH

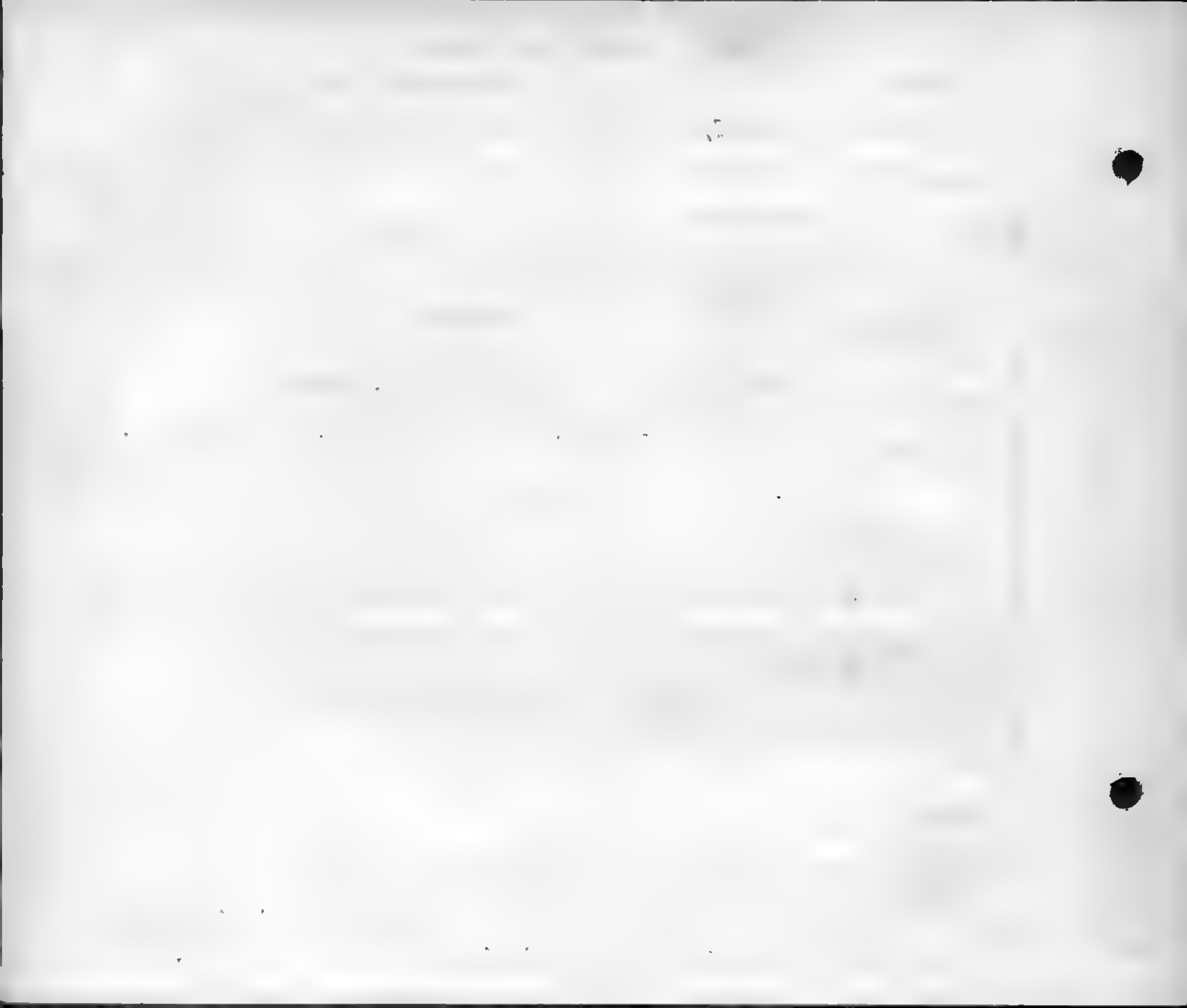
04394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u>		d. STREET ADDRESS <u>Port Deposit</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MADE</u> <u>WHITE</u> <u>THOMAS DEVONSHIRE</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>31</u> <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25, 1888</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Thomas Devonshire</u>		14. MOTHER'S MAIDEN NAME <u>Clara A. Found</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-20-1929</u>	
17. INFORMANT <u>Mrs David Curry, Aberdeen, Md.</u>		Address <u>Rural</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma of Gall Bladder</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis</u> <u>Hypostatic pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Calvert Md.</u>	
21. I certify that I attended the deceased from <u>April 14, 1959</u> to <u>April 21, 1959</u> , that I last saw the deceased alive on <u>April 21, 1959</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harford, Md.</u> DATE SIGNED <u>4/22/59</u>			
ACTUAL SIGNATURE <u>Edward C. Lee, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-24-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Bank Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Calvert Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Patterson & Sons</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REGISTRY REGISTRATION <u>APR 21 1959</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4420

CERTIFICATE OF DEATH

04395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hanford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexandria</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexandria</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bush Chapel Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Keyser</i> Last <i>Ford</i>		4. DATE OF DEATH Month <i>4</i> Day <i>28</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/7/1877</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>28</i> Hours <i>19</i> Min.	IF UNDER 24 HRS Months <i>8</i> Days <i>28</i> Hours <i>19</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. Thornton Ford</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Stockman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Mildred Cole (daughter)</i> Address <i>Alexandria Md. 2084 Bel Air Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO <i>Arterio sclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio sclerotic Heart Disease</i> DUE TO (c) <i>Arterio sclerotic Heart Disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arthritis of Rt. Hip</i>			INTERVAL BETWEEN ONSET AND DEATH <i>24 Hrs.</i> <i>3 Years.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>AN. 1</i> 19 <i>58</i> , to <i>April 27, 1959</i> , that I last saw the deceased alive on <i>April 24</i> 19 <i>59</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>André Weiss</i> M.D.		ADDRESS (Street, city or town, state) <i>114 N. Bel Air Ave, Alexandria</i>	
PHYSICIAN'S NAME (Type) <i>ANDRE WEISS M.D.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/1/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Spesutia Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Perryman Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Darnay</i>		ADDRESS <i>Alexandria, Maryland</i>	
24a. REC'D BY REGISTRAR <i>APR 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4400

CERTIFICATE OF DEATH

Reg. Dist. No. **04396**

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ham de Bruce</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hanford Mem. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Aberdeen Md</u> d. STREET ADDRESS <u>RD #3, Box 117</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>FRANK</u> Last <u>FRANKIEWITZ</u> DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1959</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 15, 1902</u> 9. AGE (in years last birthday) <u>56</u> IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beverage</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>(Deceased) Rose Dominski</u>				14. MOTHER'S MAIDEN NAME <u>(Deceased) Frank Franczkiewicz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-09-7542</u> 17. INFORMANT <u>Marie Frankiewicz</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Phenochromocytoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan. 4th, 1956</u> to <u>April 7th, 1959</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Baltimore, Md.</u> DATE SIGNED <u>4/7/59</u> ACTUAL SIGNATURE <u>Eduard C. Lee, M.D.</u> PHYSICIAN'S NAME (Type) <u>Eduard C. Lee, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM</u>		22d. LOCATION (City, town or county) <u>BALTIMORE Co. MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Katerbach</u> ADDRESS <u>401 S. Chester</u>				24a. REC'D BY REGISTRAR <u>APR 14 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur B. France</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4401

CERTIFICATE OF DEATH

04397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpers-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Thomas</u> Last <u>Fyle</u>				4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb., 19, 1909</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RANDELL BLOODSWORTH</u>				14. MOTHER'S MAIDEN NAME <u>Anne XXXXXXXX DASHIELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Leon Fyle, 353 Carter St, Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>171X Uremia and Acidosis</u> DUE TO (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Squamous Cell Ca. of Cervix</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 2nd, 1959</u> to <u>April 23rd, 1959</u> that I last saw the deceased alive on <u>April 23rd, 1959</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Harpers-de-Grace, Md.</u>				DATE SIGNED <u>4/23/59</u>			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Carrington</u>				24a. REC'D BY REGISTRAR <u>Tarrington Funeral Home</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>APR 28 '59</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

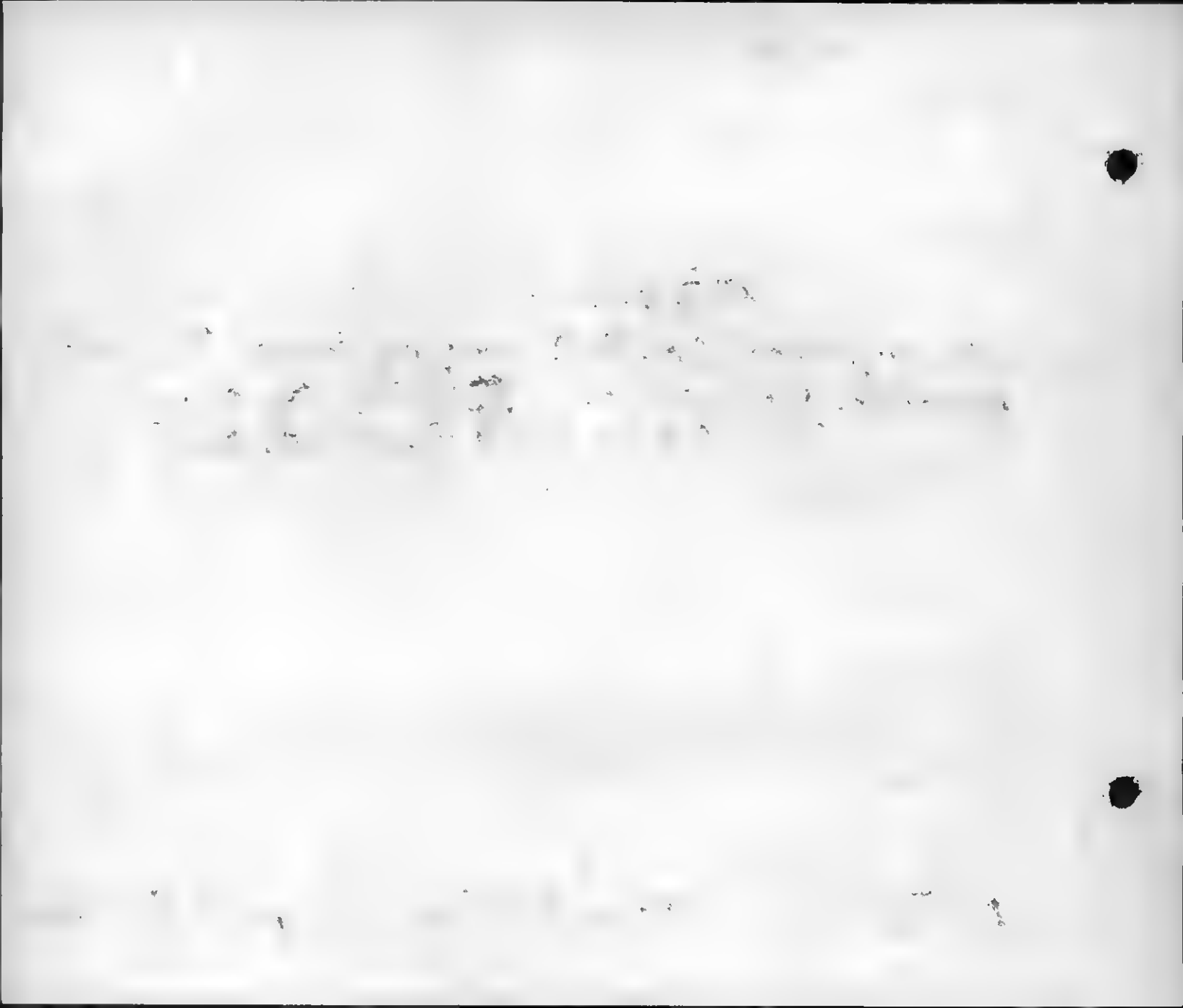
04398

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hardeen</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 2</u>		e. STREET ADDRESS <u>R.D. 2</u>	
3. NAME OF DECEASED (Type or print) <u>James A. Fred Gallion</u>		4. DATE OF DEATH <u>April 23 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>June 23 1917</u>
9. AGE (In years last birthday) <u>41</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not red) <u>Building attendant G. & H. Co. Harford Co., Md. 2 S.A.</u>			
13. FATHER'S NAME <u>Joseph J. Gallion</u>		14. MOTHER'S MAIDEN NAME <u>Estella Hughes</u>	
15. WAS DECEASED EVER IN THE ARMED FORCES? <u>No</u> (If yes, give dates of service)		16. SOCIAL SECURITY NO. <u>213-28-3279</u>	
17. INFORMANT <u>Russell Gallion R.D. 1</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2 SW Cerebrum</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>		20c. TIME OF INJURY Month, Day, Year <u>4-23-59</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Hardeen</u> (County) <u>Harford</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Bel Air, MD 4-23-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL OR CREMATION (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 26 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cem</u>		22d. LOCATION (City, town, or county) <u>Harford Co., MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harley Harlingen</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hanes</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>APR 28 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4402

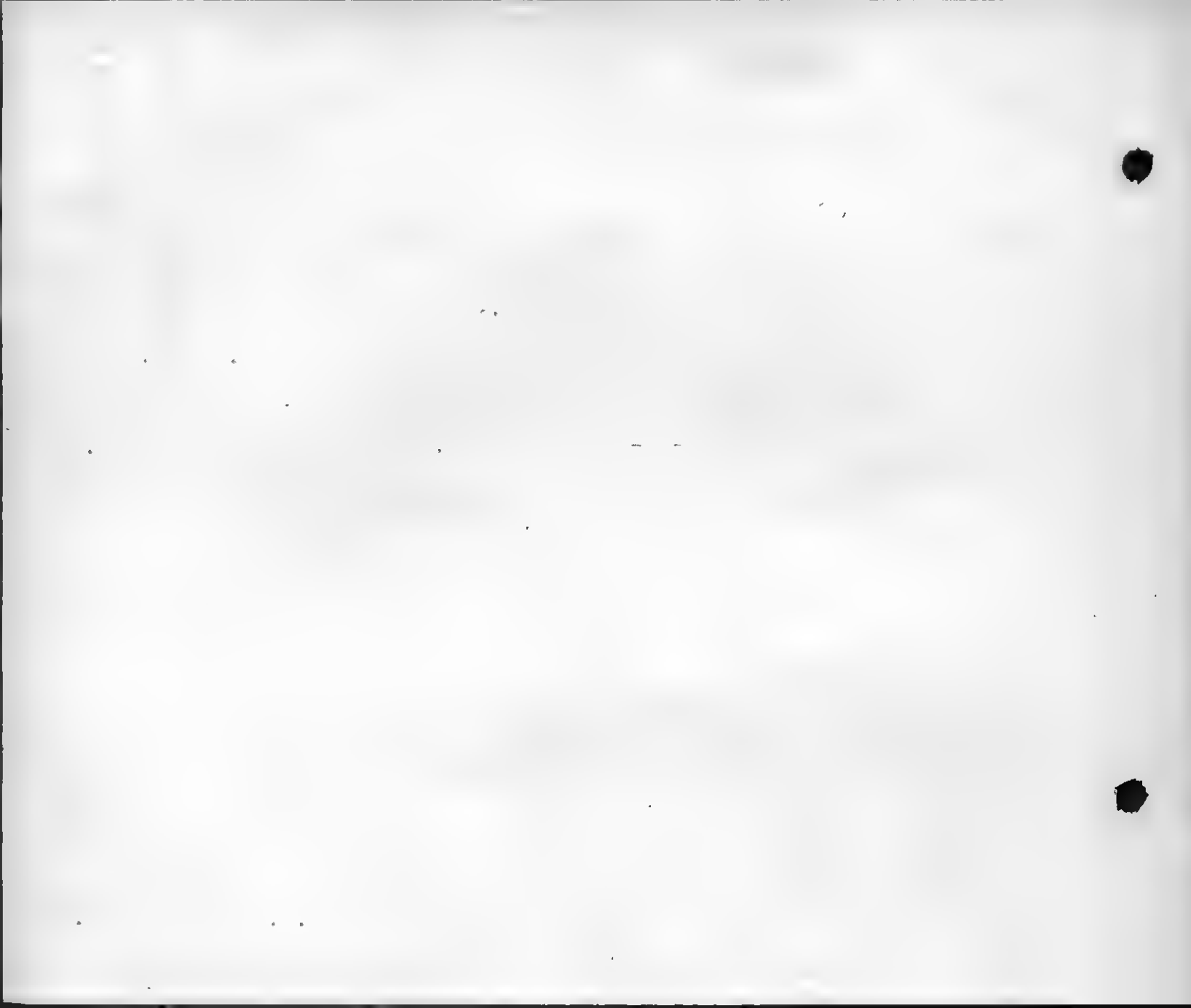
CERTIFICATE OF DEATH

04399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gorsey Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Magie</u> First <u>Holland</u> Middle <u>Holland</u> Last		f. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb., 6, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Robert Holland</u>		14. MOTHER'S MAIDEN NAME <u>Estella Black</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>222-10-7929</u>	
17. INFORMANT <u>Agnes A. Carney</u>		Address <u>512 Lumbard St. Wilmington, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypochromic Anemia</u> DUE TO (c) <u>Bleeding from Bladder Carcinoma of Bladder</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u> <u>5 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-9-59</u> to <u>4-9-59</u> , that I last saw the deceased alive on <u>4-9-59</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <u>8 Lw St - Aberdeen, Md.</u>	
ACTUAL SIGNATURE <u>John P. Rodman, M.D.</u>		DATE SIGNED <u>4/10/59</u>	
PHYSICIAN'S NAME (Type) <u>John P. Rodman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery, R.D. Aberdeen, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		24a. REC'D BY REGISTRAR <u>APR 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 4422 CERTIFICATE OF DEATH

04400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN 1b <u>109</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Hofkins</u> Middle <u>W</u> Last		4. DATE OF DEATH <u>April 20</u> Month <u>April</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u> RACE <u>White</u>		7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired dairy farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co, Md</u>	
11. BIRTH PLACE (State or foreign country) <u>Harford Co, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Hofkins</u>		14. MOTHER'S MAIDEN NAME <u>Annie Harber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (If yes, give dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Isabelle Brown</u> Address <u>Darlington Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>10 cm</u>		INTERESTED PERSONS AND DEATH SETTING <u>2 col</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diphtheria</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> 19 <u>47</u> , to <u>April 20</u> 19 <u>59</u> , that I last saw the deceased alive on <u>April 19</u> 19 <u>59</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips M.D.</u>		ADDRESS (Street, city or town, state) <u>Darlington</u> DATE SIGNED <u>April 20/59</u>	
PHYSICIAN'S NAME (Type) <u>Darlington Md</u>		<u>Dudley Phillips M.D.</u>	
22a. BURIAL, CREMATION, or other disposal <u>buried</u>		22b. DATE THEREOF <u>April 23, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Am</u>		22d. LOCATION (city, town, or county) (state) <u>Harford Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		23b. REC'D BY REGISTRAR <u>Arthur L. Frank</u> DATE <u>APR 28 '59</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4403

CERTIFICATE OF DEATH

04402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hosp.</u>				d. STREET ADDRESS <u>1563 OTSEGO ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>Reynolds</u> Last <u>Kiescale</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20, 1883</u>	9. AGE (In years last birthday) <u>75</u> yrs.	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Thomas Reynolds</u>				
14. MOTHER'S MAIDEN NAME <u>Katherine Schutt</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Mrs. Wm. R. Spier</u> <u>Daughter Haverde Grace, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>Cardio-renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH _____		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____		
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____		
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>58</u> , to <u>April 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-6</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>C. L. Lewis MD</u> M.D. <u>Haver de Grace Md</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>			
22d. LOCATION (City, town, or county) <u>Haver de Grace</u>		(State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Madison Twitchell</u>			24a. REC'D BY REGISTRAR <u>APR 9 '59</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraser</u>			24c. ADDRESS <u>Haver de Grace Md.</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.



4404

CERTIFICATE OF DEATH

04403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Caroline		Middle M		Last Lilley	
		4. DATE OF DEATH		Month 4		Day 23	
				Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 10, 1883		9. AGE (In years last birthday) yrs. 75	
				IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				Months		Days	
				Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Biddle				14. MOTHER'S MAIDEN NAME Rosa Brower			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Carleton Robertson			
				Address Havre de Grace, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis							3 hours
DUE TO							
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) arteriosclerosis cerebral							2 years
DUE TO							
(c) Generalized Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 to April 23, 1959 , that I last saw the deceased alive on April 23, 1959 , and that death occurred at 4 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John L. Woodrum		M.D. 407 S. WILSON AVE		ADDRESS (Street, city or town, state) Havre de Grace, Md		DATE SIGNED 4/25/59	
PHYSICIAN'S NAME (Type)							
22a. REMOVAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 4-26-1959		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55



1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
V5 155C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

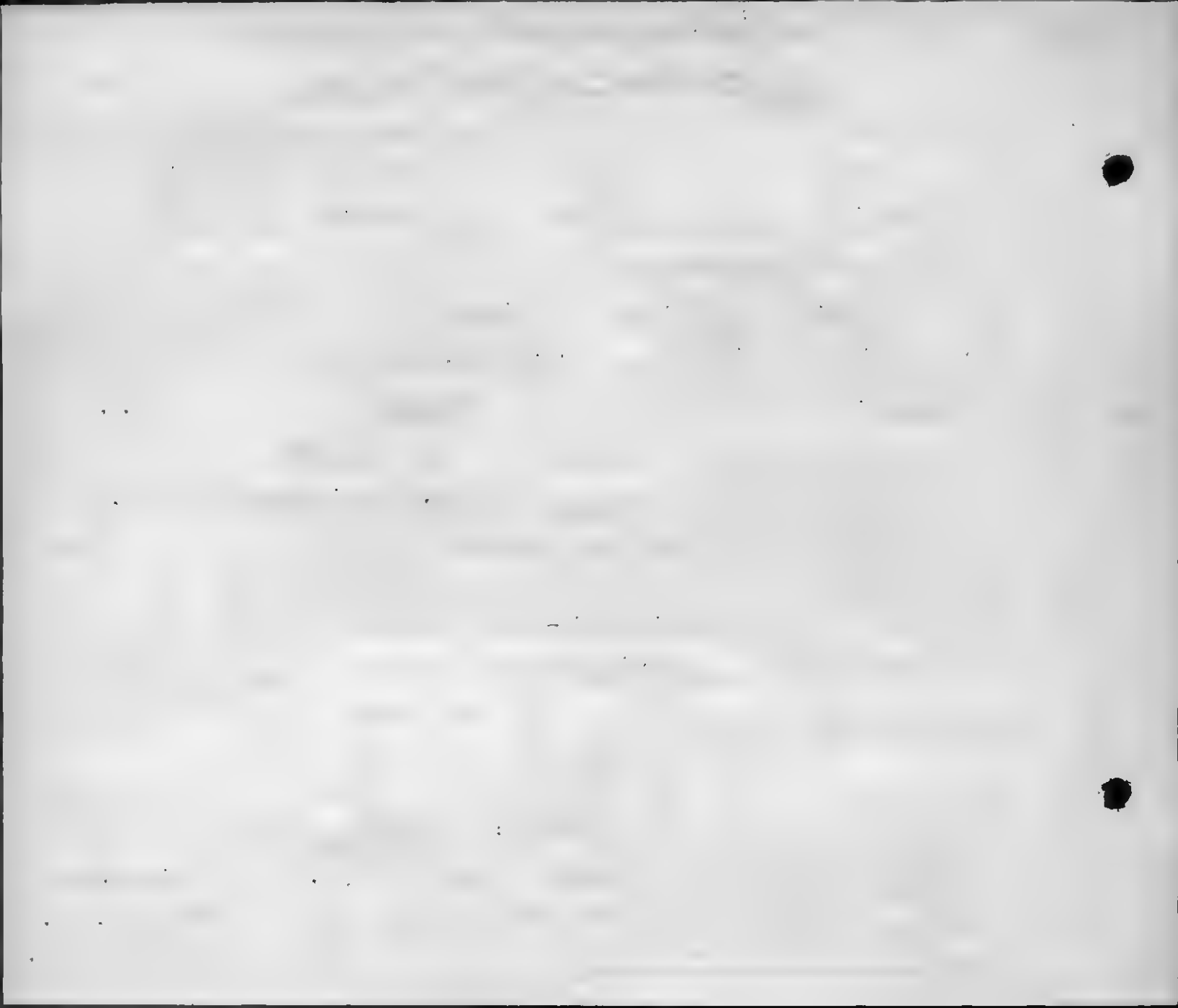
CERTIFICATE OF DEATH

4405

04404

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Maryland		COUNTY Cecil			
CITY (If outside corporate limits, write RURAL and give nearest town) Bel Air		LENGTH OF STAY (in this place) 2 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) Perryville			
TOWN				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Convalescent Home							
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Alexander Jackson Little				4. DATE OF DEATH (Month) (Day) (Year) April 20 1959			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH February 21, 1873	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Little				14. MOTHER'S MAIDEN NAME Eleanor Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. John Little, Perryville, Md.	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Lobar Pneumonia, terminating				INTERVAL BETWEEN ONSET AND DEATH 48 hours			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Chronic Cardio-vascular Disease				?			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) Senile Dementia				?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 9 , 19 59 to April 20 , 19 59 , that I last saw the deceased alive on April 19 , 19 59 , and that death occurred at 9:00 PM , from the causes and on the date stated above. SIGNATURE Willard P. Henderson M.D. ADDRESS Forest Hill Md. DATE SIGNED April 21, 1959							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-23-59		NAME OF CEMETERY OR CREMATORY Principio Cemetery		LOCATION (City, town, or county) (State) Principio Furnace, Md.	
24. REC'D BY REGISTRAR DATE APR 24 '59		REGISTRAR'S SIGNATURE Clara S. Hana		25. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson ADDRESS Perryville, Md.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

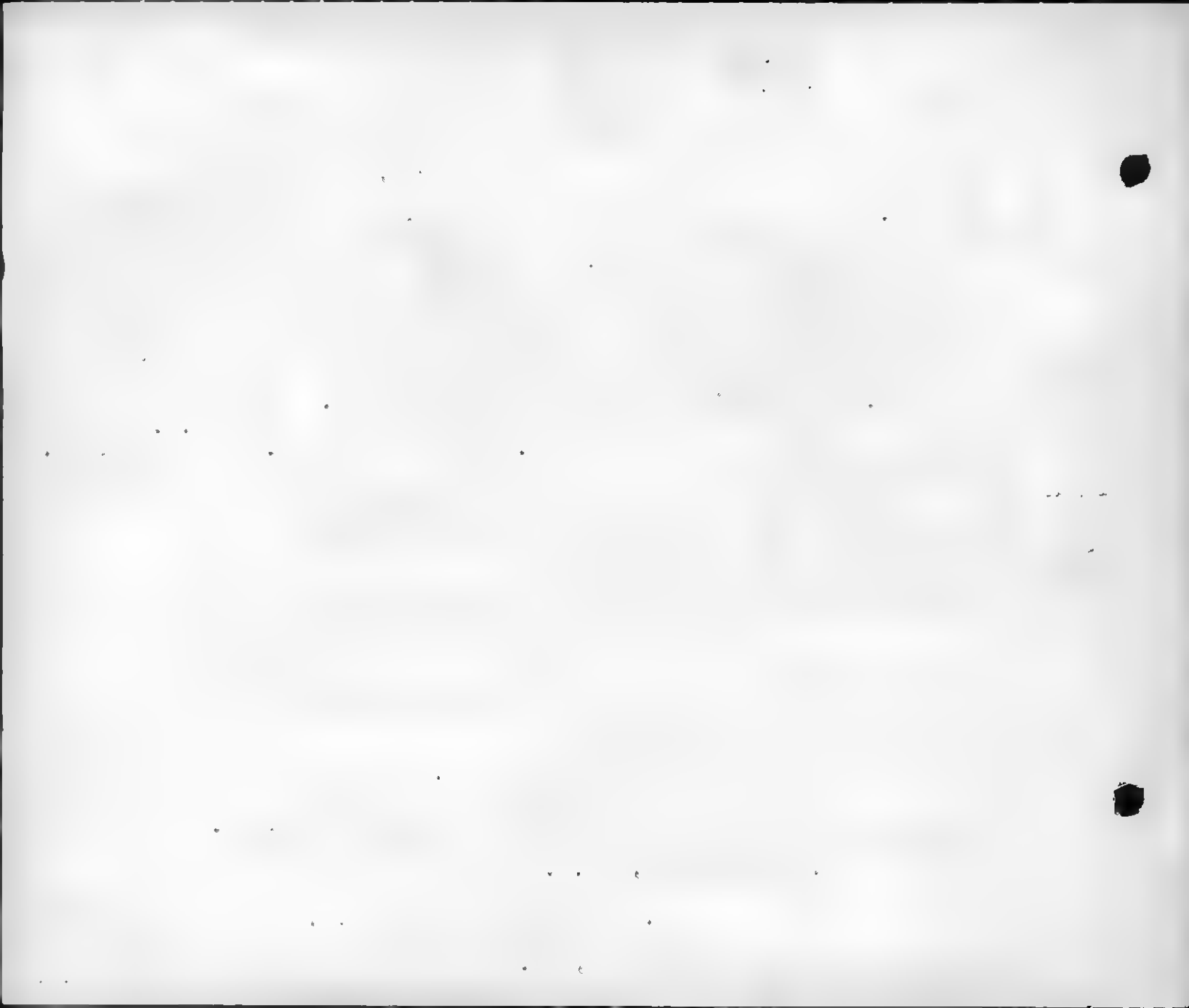
CERTIFICATE OF DEATH

04405

Reg. Dist. No.

4423

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1		d. STREET ADDRESS R.D. #1	
3. NAME OF DECEASED (Type or print) First SUSAN Middle M. Last LOCHARY		4. DATE OF DEATH Month April Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 August 1889
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months 10 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME E. Hall Harkins		14. MOTHER'S MAIDEN NAME Ella A. Mahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT Mrs. Albert Jersey Jr.		Address R.D. 1, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Disease DUE TO (c) Sudden		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Non-toxic Goiter		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1956 to April 1959 , that I last saw the deceased alive on April 8, 1959 , and that death occurred at 2:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Ralph Horky		ADDRESS (Street, city or town, state) Churchville, Md. DATE SIGNED April 11, 1959	
PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/59	
22c. NAME OF CEMETERY OR CREMATORY St. Ignabius Cemetery		22d. LOCATION (City, town, or county) (State) R.D., Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John B. Tarring		24a. REC'D BY REGISTRAR APR 14 '59	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Brown	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Filed 4-28-59 et

CERTIFICATE OF DEATH

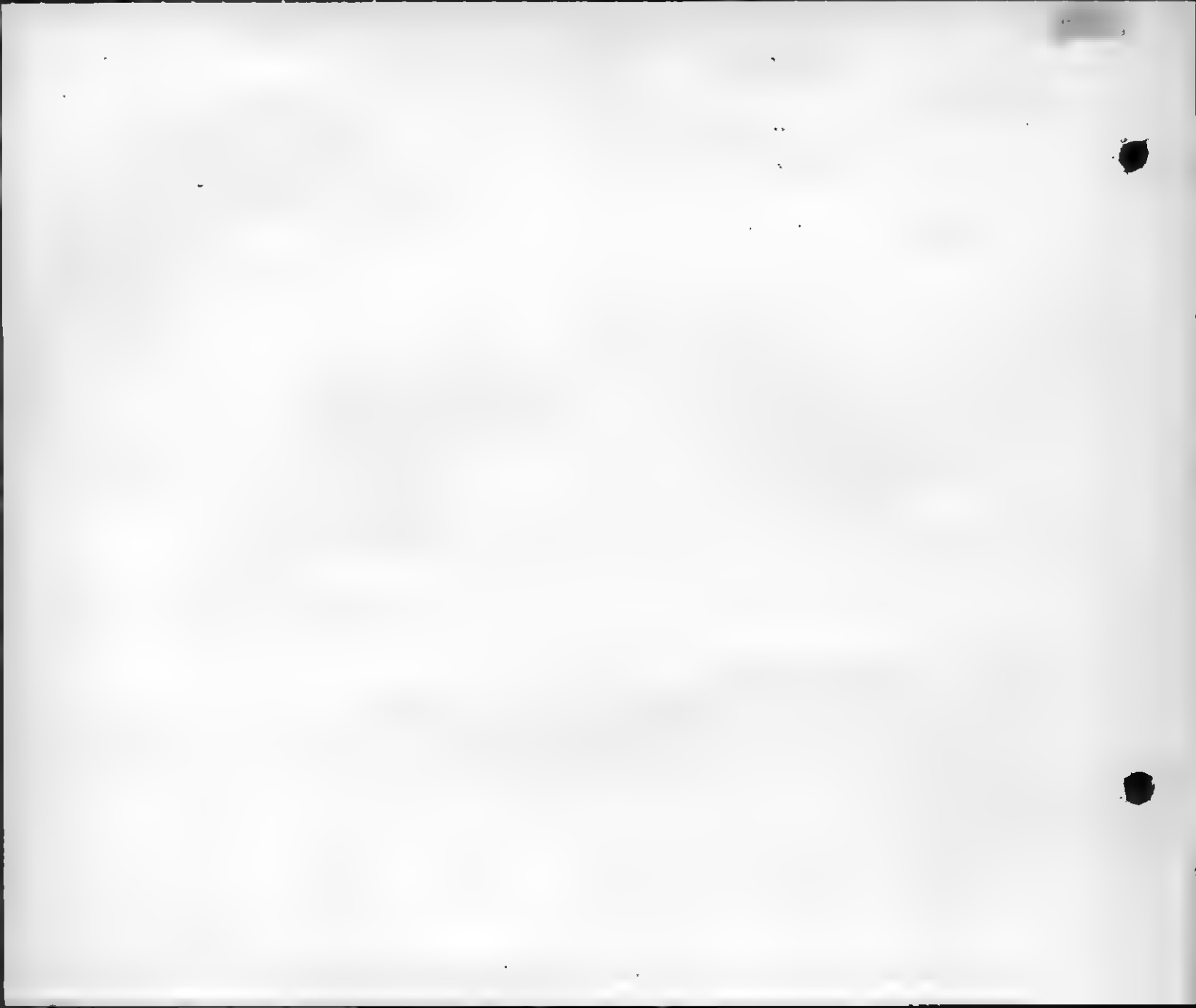
04406

4406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u> c. LENGTH OF STAY IN lb <u>9 mo</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u> d. STREET ADDRESS <u>621 Freedom</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Lunsford</u> Last <u>Lunsford</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/2/1885</u>
9. AGE (in years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Lunsford</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Richard Lunsford</u> Address <u>621 Freedom Harford Chase Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Tuberculosis (Arrested)</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>April 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>59</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Harford Chase Md.</u> DATE SIGNED <u>4/15/59</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Chase Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Ray</u> ADDRESS <u>Harford Chase</u>		24a. REC'D BY REGISTRAR <u>APR 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4424

CERTIFICATE OF DEATH

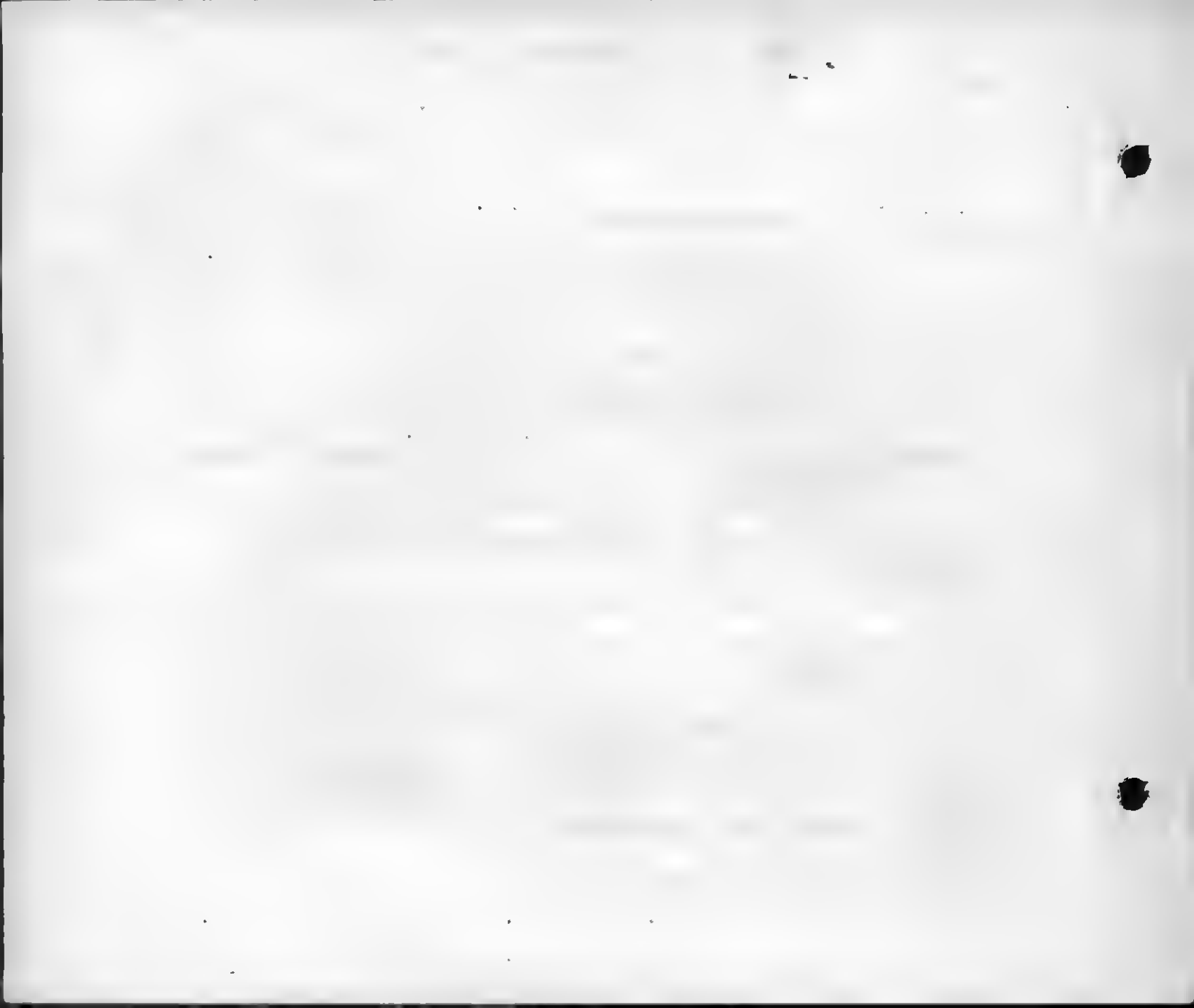
04407

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Harford		MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md.		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. 2 - Box 74				d. STREET ADDRESS R. D. 2, Box 74		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		First NELLIE		Middle RUTH		Last MATTINGLY	
5 SEX female		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min		4. DATE OF DEATH APR. 28, 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11 BIRTHPLACE (State or foreign country) Md.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Charles Bagley				14. MOTHER'S MAIDEN NAME Eleanor Virginia McCauley			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17 INFORMANT Mr. Donald E. Mattingly - Box 74-R D 2, Fallston			
18. CAUSE OF DEATH [Enter only one cause or name for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Diabetes mellitus, mild Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1956 , 19____, to April 28 , 19 59 , that I last saw the deceased alive on April 28 , 19 59 , and that death occurred at 10:41 A.M. from the causes and on the date stated above Charles Frederick M.D. ADDRESS (Street, city or town, state) Bel Air Md. DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/59		22c. NAME OF CEMETERY OR CREMATORY St. John's Cem.		22d. LOCATION (City, town, or county) (State) Kingsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Ticker & Sons - Baltimore		24a. REC'D BY REGISTRAR DATE APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

VS A15 (4)
15M 10/37

VS A15 (4)
15M 10/57



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 11M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4425 CERTIFICATE OF DEATH

04408

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY <u>Jarrettsville</u>		TOWN <u>Jarrettsville</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Bel Air rural</u>		<u>1 Month</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford convalescent Home</u>				1			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>George Miller</u>				<u>April 20 1959</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>April 6, 1927</u>	<u>65</u> Yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Homemaker</u>		<u>None</u>		<u>Johns Hopkins, Md.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John E. Ensor</u>				<u>Elizabeth Chilcoat</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>John E. Miller, Jr., Jarrettsville, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24h</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch. Cerebro-Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19, 1959</u>, to <u>April 20, 1959</u>, that I last saw the deceased alive on <u>April 19, 1959</u>, and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson, M.D.</u>				DATE SIGNED <u>April 20, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>Jarrettsville</u>		<u>Jarrettsville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>APR 24 '59</u>		<u>Charles E. Hunt</u>		<u>Charles E. Hunt</u>		<u>Jarrettsville Md.</u>	



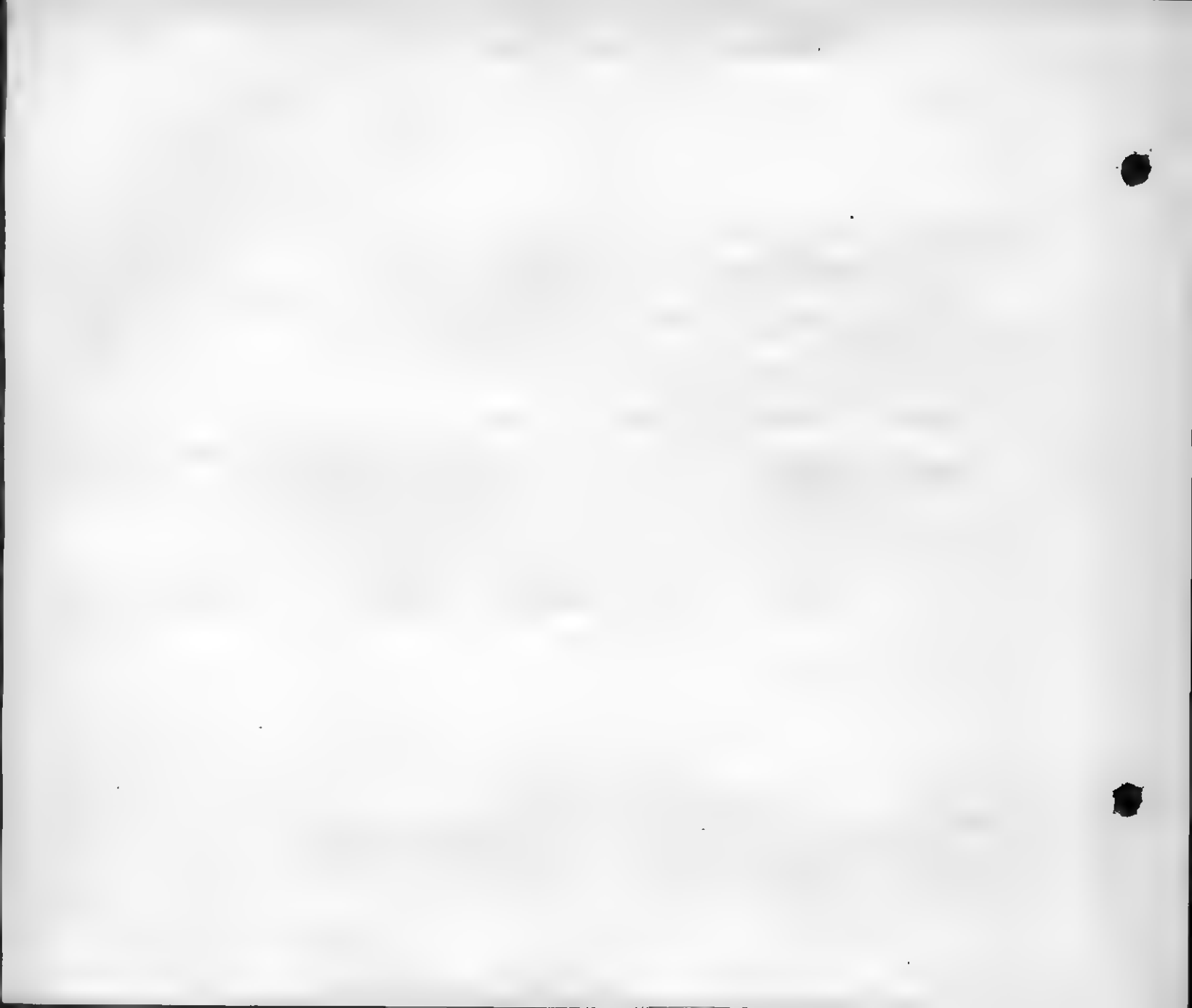
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04409
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>18 years</u>		d. STREET ADDRESS <u>RD 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2</u>		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Neal</u> Last <u>Moretz</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 13-1891</u>
9. AGE (in years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ashe NC</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Moretz</u>		14. MOTHER'S MAIDEN NAME <u>Julia Trickett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>719-07-9810</u>	
17. INFORMANT <u>MRS Ruby M Lewis</u> Address <u>ALINGTON HARTFORD CO MD BOX 258</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Cervical Vertebra</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost, DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crushing injury chest</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Ante accident ante pedestrian type</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month <u>4</u> Day <u>4</u> Year <u>59</u> Hour <u>1:25</u> m <u> </u> s <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 22</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>4-4-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>APRIL 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Big Flatts Baptist</u>	
22d. LOCATION (City, town, or county) <u>Bel Air</u> (State) <u>Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



4427

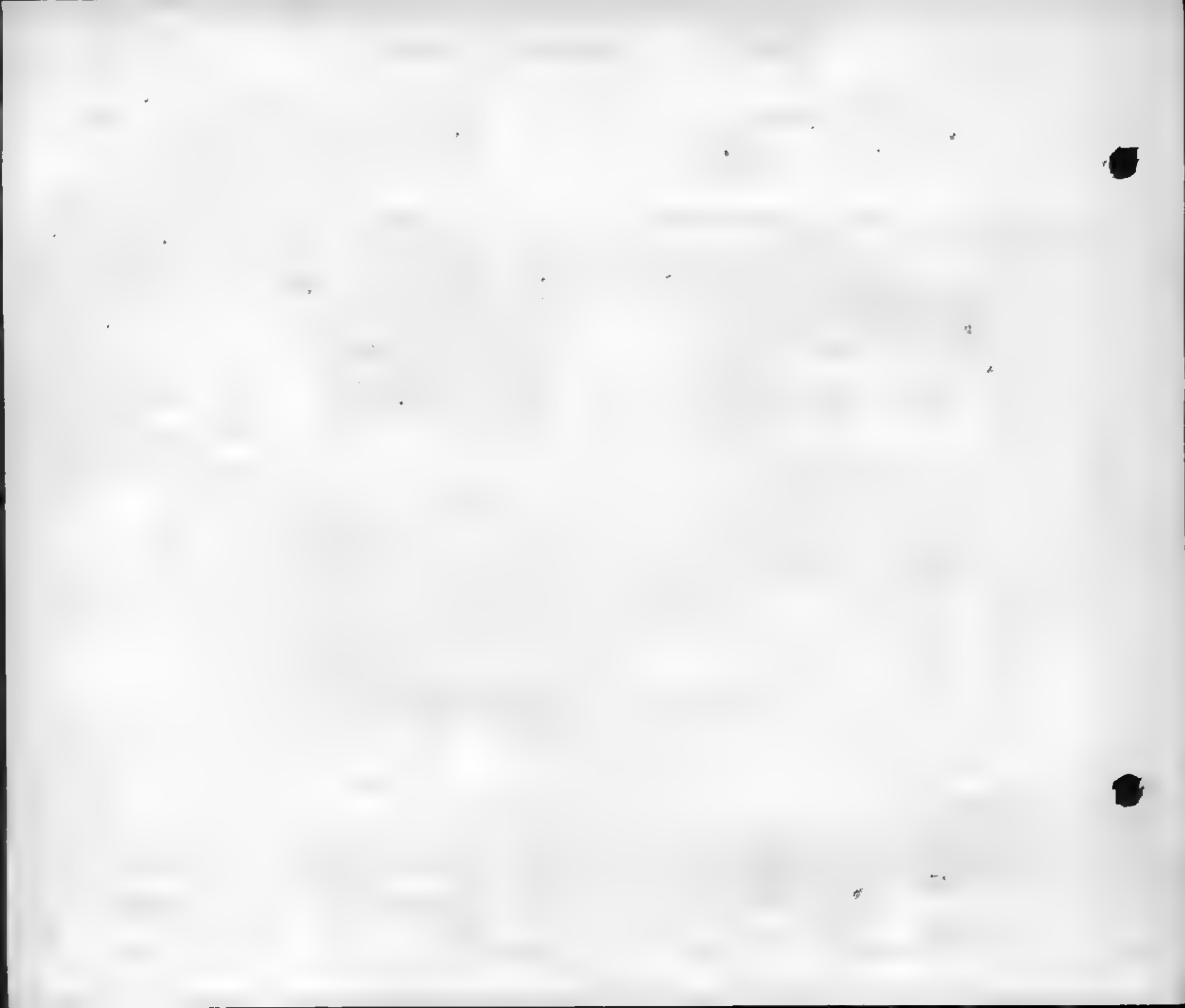
CERTIFICATE OF DEATH

04410

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Henry H. Powers</u>		4. DATE OF DEATH <u>April 18</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>Nov. 21, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ash Co. M.C., U.S.A.</u>	
12. FATHER'S NAME <u>Andrew J. Powers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Caudill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>245-14-0840</u>	
17. INFORMANT <u>Mrs. Henry Powers</u>		Address <u>Carlington, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 3</u> 19 <u>52</u> , to <u>4/18</u> 19 <u>59</u> , that I last saw the deceased alive on <u>4/12</u> 19 <u>59</u> , and that death occurred at <u>1304</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		DATE SIGNED <u>4/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips M.D.</u>		ADDRESS (Street, city or town, state) <u>Darlington, Maryland</u>	
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/>	22b. DATE THEREOF <u>April 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bell Air Memorial Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Bailey</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	
REMOVED (Specify)		24a. REC'D BY REGISTRAR <u>APR 21 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04411

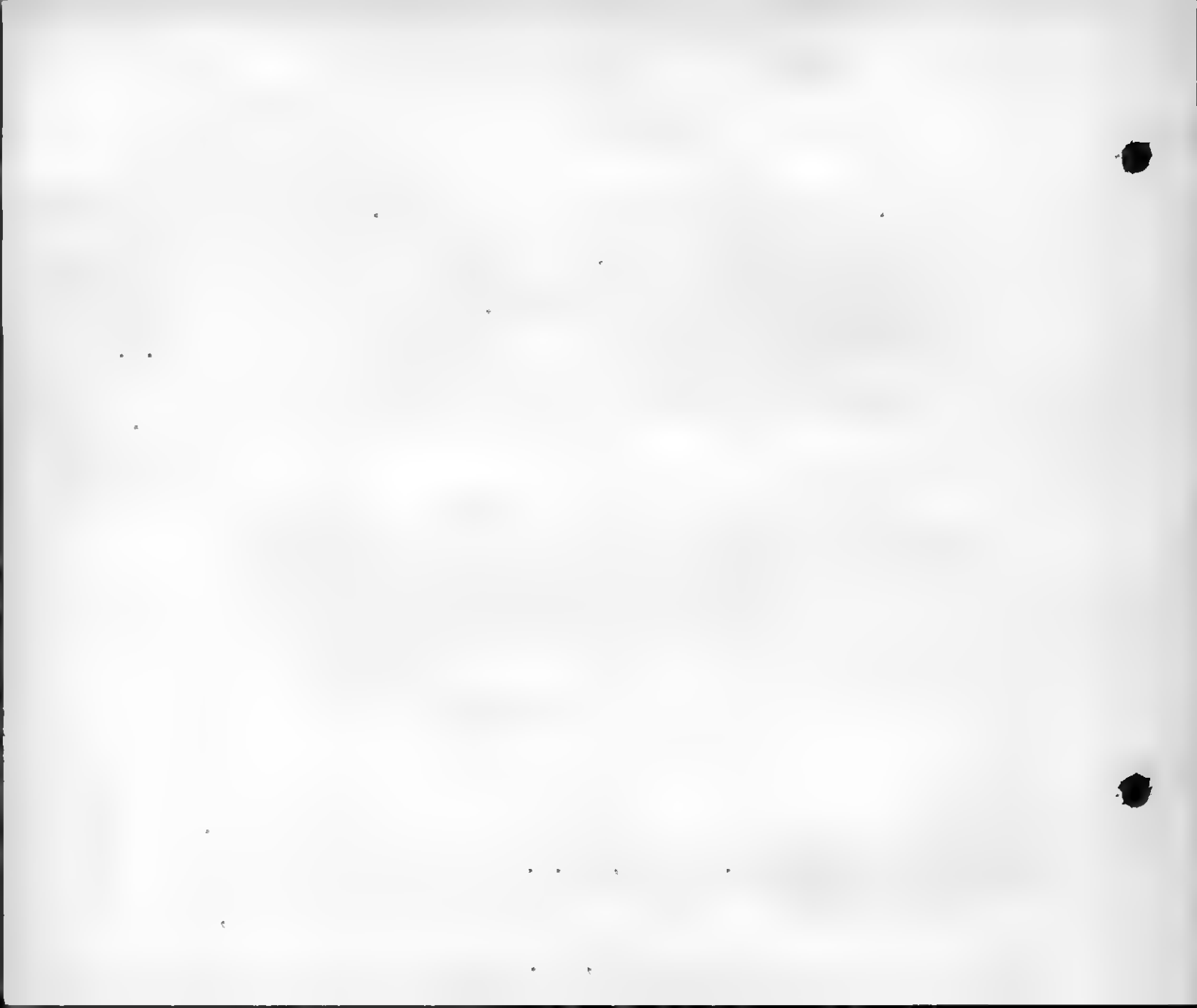
Reg. Dist. No.

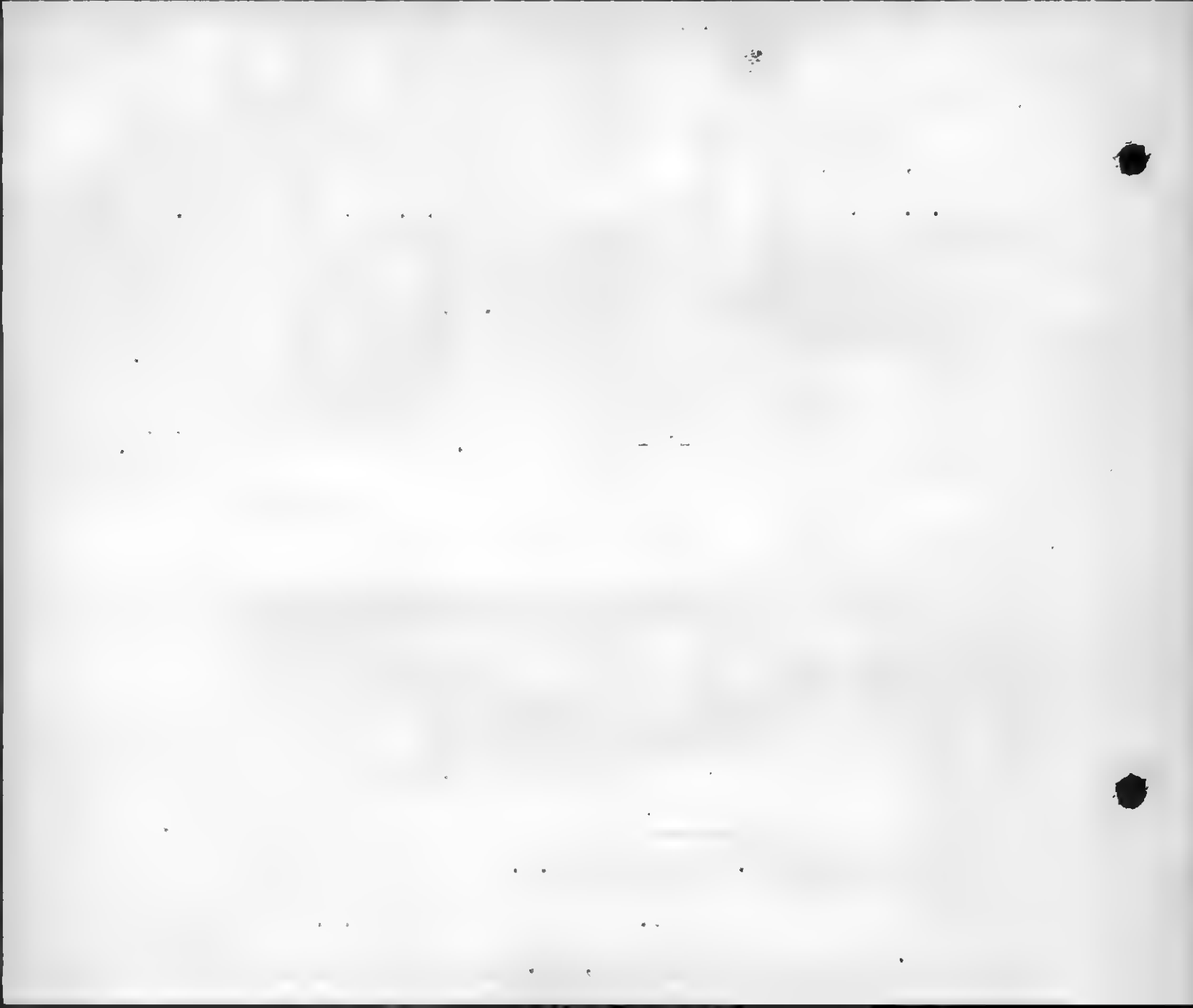
4407

1 PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b 21 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 64 Mt. Royal Avenue		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS 64 Mt. Royal Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last MARTHA M. RAGAN		4 DATE OF DEATH Month Day Year April 26 19 59	
5. SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME John Wesley Arrison		14. MOTHER'S MAIDEN NAME Mary Frances McVey	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO ---	
17. INFORMANT Mrs. Thomas Welsh, Aberdeen, Maryland		Address 64 Mt. Royal	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Occlusion (c) Cardiac decompensation			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-11 , 19 59 , to 4-26 , 19 59 , that I last saw the deceased alive on 4-21 , 19 59 , and that death occurred at 12:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 421 Congress Ave.			
ACTUAL SIGNATURE Gunther D. Hirsch		M.D. Gunther D. Hirsch, M.D.	
PHYSICIAN'S NAME (Type) Gunther D. Hirsch, M.D.		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/59	22c. NAME OF CEMETERY OR CREMATORY North East Cemetery	22d. LOCATION (City, town, or county) (State) North East, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Tarring Funeral Home, Aberdeen, Md.	
24a. REC'D BY REGISTRAR APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4429

CERTIFICATE OF DEATH

114413
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Bel-Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D.#1 Box 357</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Vincent</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-1912</u>
9. AGE (In years last birthday) <u>46</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wardens Home Ground, Red Star, H. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harry B. Rose</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bryant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 1942-1946		16. SOCIAL SECURITY NO. <u>236-05-3125</u>	
17. INFORMANT <u>Mrs. Martha Boone - Bel-Air, Md.</u>		Address <u>R.F.D.#1 Box 357</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 27</u> , 19 <u>59</u> , to <u>March 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 31</u> , 19 <u>59</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Havre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>4/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-4-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Bullock - Havre de Grace</u>		ADDRESS <u>1424</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and no later than 72 hours after death.



4408

CERTIFICATE OF DEATH

04414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>4 years</u>		d. STREET ADDRESS <u>1 722 S. Main St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>722 S. Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>Scrippens</u> Last <u>Scrippens</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29 - 1920</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LANSING N. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Calvin W. Sexton</u>		14. MOTHER'S MAIDEN NAME <u>Bessie E. Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>217-16-0590</u>	
17. INFORMANT <u>John Scrippens</u> Address <u>722 S. Main St Bel Air, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma R. breast with metastases</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1959</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>59</u> , to <u>4-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-12</u> , 19 <u>59</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md</u> DATE SIGNED <u>4-14-59</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer, M.D.</u>		ADDRESS <u>Bel Air, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>April 16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harlington</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REGISTERED BY REGISTER <u> </u> DATE <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4409

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>Rt. 2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lloyd</i> Middle <i>H.</i> Last <i>Shue</i>				4. DATE OF DEATH Month <i>April</i> Day <i>6</i> Year <i>1957</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5 1900</i>	9. AGE (In years last birthday) <i>58</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mech. electric</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Auto.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Isreal Shue</i>				14. MOTHER'S MAIDEN NAME <i>Emma Kilbough</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <i>185-09-1878</i>		17. INFORMANT <i>Mrs. Roberta Shue</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fast Operative Hemorrhage</i> <i>180X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>Right Nephros long</i> DUE TO (c) <i>Carcinoma R. Kidney</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>2 1/2 hrs.</i> <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerotic Cardiovascular Disease with Coronary Sclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2:35 P.M.</i> 19 <i>57</i> to <i>12:15 P.M.</i> 19 <i>57</i> , that I last saw the deceased alive on <i>6 April</i> 19 <i>57</i> , and that death occurred at <i>2:35 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6005 Union Ave. Harford, Md.</i> DATE SIGNED <i>4/6/57</i>							
ACTUAL SIGNATURE <i>H. S. Sadowsky</i> M.D.				PHYSICIAN'S NAME (Type) <i>H. S. SADOWSKY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>April 9, 1957</i>		<i>New Freedom Cemetery</i>		<i>New Freedom, Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Isaac Harleinstein, New Freedom, Pa.</i>				24a. REC'D BY REGISTRAR DATE <i>APR 8 '57</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4410

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp.				d. STREET ADDRESS 54 N. Main			
3. NAME OF DECEASED (Type or print) Baby Boy First Slayman Middle Last				4. DATE OF DEATH April 3 1959 Month Day Year			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-59	
9. AGE (In years last birthday) 2 yrs		10. IF UNDER 1 YEAR Months 2 Days 43		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Robert Richard Slayman				14. MOTHER'S MAIDEN NAME HELEN ELIZABETH SHOUEMAKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 7:5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EXTREME PREMATUREITY (Birth wt 1#11g) DUE TO (c) PARTIAL SEPARATION OF PLACENTA (PREMATURE)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-4-59 , 19 59 , to 4-4-59 , that I last saw the deceased alive on 4-4-59 , 19 59 , and that death occurred at 11:10 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perryville, Md. DATE SIGNED APR 6 '59							
ACTUAL SIGNATURE Robert R. Slayman M.D.				PHYSICIAN'S NAME (Type) Robert R. Slayman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-1959		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		22d. LOCATION (City, town or county) (State) Colora, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Will A. Satterthwaite ADDRESS Perryville, Md.				24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Robert R. Slayman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4430 CERTIFICATE OF DEATH

04417

Reg. Dist. No.....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>HARFORD</u>
CITY (if outside corporate limits, write RURAL and give nearest town) TOWN <u>WHITEFORD</u>	LENGTH OF STAY (in this place) <u>15 YRS.</u>	CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WHITEFORD</u>	STREET ADDRESS (if rural give location) <u>1</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Catherine Elizabeth Stewart</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 12, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>18 April, 1879</u>
9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>RONKS, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY BROWNSBERGER</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA GOLDFUS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>FRANCIS H. STEWART, WHITEFORD, MD.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
IMMEDIATE CAUSE (A) <u>Diabetes mellitus - & uremia.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 yr +</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC cardiovascular</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>disease</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>11 Apr</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11 Apr</u> , 19 <u>59</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edward W. Whitford Jr. M.D.</u>		ADDRESS (Street, city, town, state) <u>Whitford Maryland</u>	
DATE SIGNED <u>4/12/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-16-59</u>	
NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>		LOCATION (City, town, or county) (State) <u>PLEYSVILLE, MD.</u>	
24. REC'D BY REGISTRAR <u>APR 14 '59</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Haskins, Delta, Pa.</u>	
REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>		ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

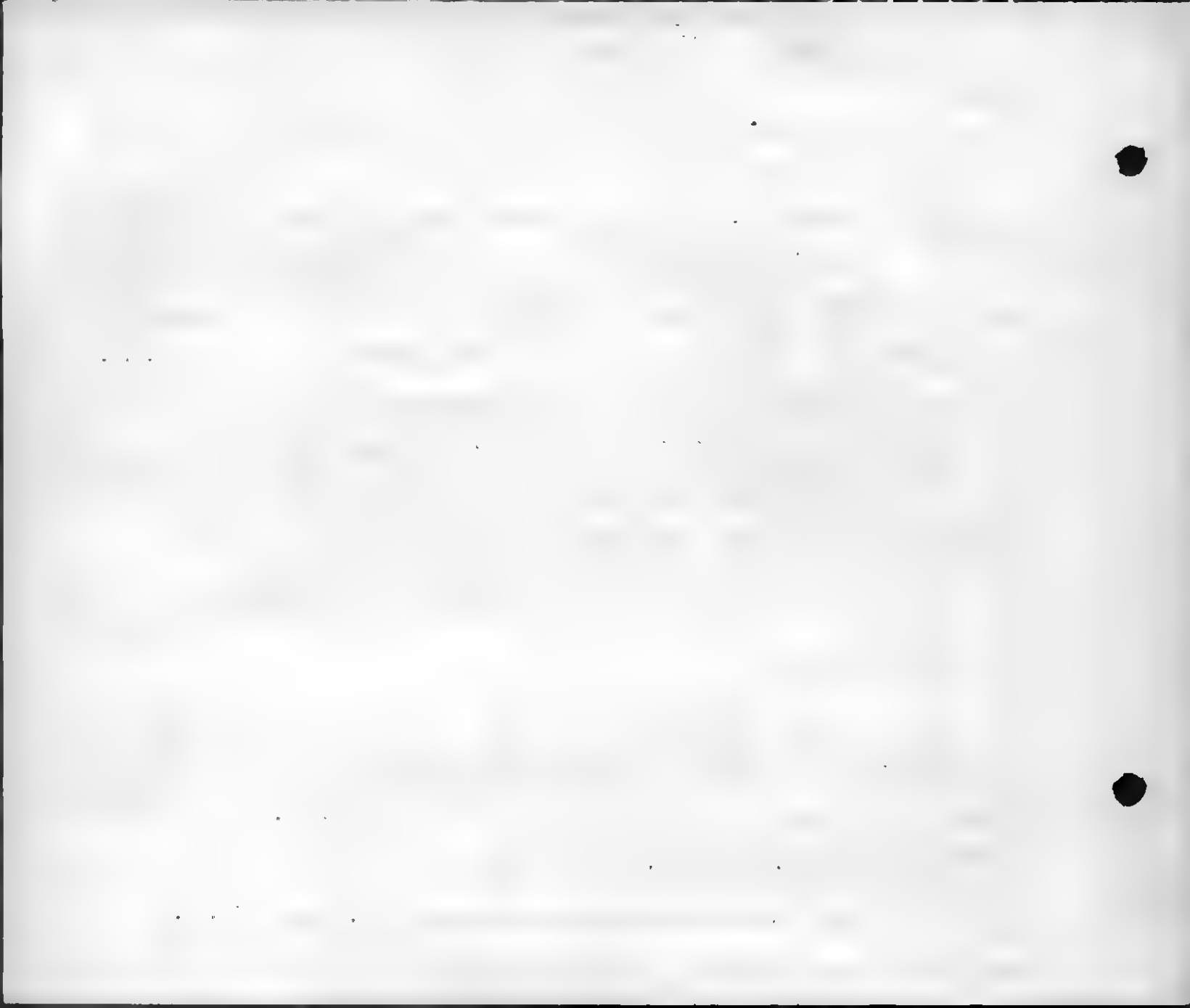
4411

CERTIFICATE OF DEATH

04418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>133 Thomas Street</u>				d. STREET ADDRESS <u>133 Thomas Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Coza</u> Middle <u>Lee</u> Last <u>Suite</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1888</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lee Green Pilkins</u>				14. MOTHER'S MAIDEN NAME <u>Carolyn Casey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-20-5596</u>		17. INFORMANT <u>John A. Suite, Bel Air, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebro-vascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 10</u> , <u>1959</u> , to <u>April 16</u> , <u>1959</u> , that I last saw the deceased alive on <u>April 16</u> , <u>1959</u> , and that death occurred at <u>10:00a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u>			
DATE SIGNED <u>4-17-59</u>							
OFFICIALS NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Baptist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Rt. #2, Bel Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	



4431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04419

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD ROCKS</u>		c. LENGTH OF STAY IN 1b <u>55 YRS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHARON Rd</u>		e. STREET ADDRESS <u>SHARON Rd</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLS</u> First <u>AMOS SWEETING</u> Middle Last		4. DATE OF DEATH <u>APRIL 26</u> 19 <u>59</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>JULY 19, 1903</u>	9. AGE (In years last birthday) <u>55</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>ROCKS, MARYLAND</u>
13. FATHER'S NAME <u>GEORGE W. SWEETING</u>		14. MOTHER'S MAIDEN NAME <u>EUGENIA AMOS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	17. INFORMANT <u>WILSON SWEETING</u> Address <u>ROCKS, Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>476 x GUNSHOT WOUND ENTERING HEAD</u> DUE TO (b) <u>THRU MOUTH UNDER TONGUE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>SUICIDE</u>			<u>INSTANT</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>SUICIDE</u>	
20c. TIME OF INJURY Month, Day, Year <u>7 a.m. APRIL 24 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) (County) (State) <u>ROCKS, HARFORD, Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN, MD.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wm. Watson</u>		22d. LOCATION (City, town, or county) (State) <u>Carleton Heights, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin S. Kurtz</u> ADDRESS <u>Laurelville</u>		24a. REC'D BY REGISTRAR <u>DATE APR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Orlino S. King</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04420

4432

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	c. LENGTH OF STAY IN 1b <u>12 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Otter Point Road</u>		d. STREET ADDRESS <u>Otter Point Road</u>	
3. NAME OF DECEASED (Type or print) <u>W. H. Tefke</u>	4. DATE OF DEATH <u>April 22 1959</u>	5. RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-76</u>
9. AGE (In years last birthday) <u>83 yrs</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Dorchester co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Moore</u>		14. MOTHER'S MAIDEN NAME <u>Florence Hurley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO <u>None</u>	17. INFORMANT <u>John L. Tefke</u> Address <u>Box 132 Otter Pt Rd, Abingdon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: <u>Arteriosclerotic CV disease</u>			
IMMEDIATE CAUSE (a) <u>4</u> DUE TO (b) <u>1</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>0</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		DATE SIGNED <u>4-22-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-25-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Stemmers Run, Balto. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessahn Funeral Home</u>		24a. REC'D BY REGISTRAR <u>DATE APR 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4433 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

04421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Tiller Last Tiller		4. DATE OF DEATH Month April Day 1 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR: Months 61 Days 1 Hours 19 Min 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Dave Tiller		14. MOTHER'S MAIDEN NAME Mary Barton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 228-09-8132	
17. INFORMANT Jettie B. Tiller, Address Joppa, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Bladder (Keratinizing type) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Keratinizing type) (c) (Keratinizing type)		INTERVAL BETWEEN ONSET AND DEATH 15 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 25, 1957 to 4/1, 1959 , that I last saw the deceased alive on 4/1, 1959 , and that death occurred at 6:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford F. Hudson M.D.		ADDRESS (Street, city or town, state) Fork, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) Clifford F. Hudson		Fork, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Apr. 3, 1959	22c. NAME OF CEMETERY OR CREMATORY Gent Funeral Home	22d. LOCATION (City, town, or county) (State) Honaker, Russell Co., Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE Howard A. McKinnis ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR APR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4412

CERTIFICATE OF DEATH

04422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>NEW MEXICO</u> b. COUNTY <u>LEA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TATUM (RURAL) BOX 123</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 NO. KELLY AVE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE (NONE) WATKINS</u>		4. DATE OF DEATH Month Day Year <u>APRIL 30 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 27, 1899</u> 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RANCHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CATTLE</u>	
11. BIRTHPLACE (State or foreign country) <u>MISSISSIPPI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SIDNEY DANIEL WATKINS</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE CASSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>525-48-3485</u> (SON) WAYNE WATKINS, BEL AIR, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARDIAC INSUFFICIENCY</u> DUE TO (c) <u>OVER 4 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 20 MIN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 27, 1959</u> to <u>APRIL 30, 1959</u> , that I last saw the deceased alive on <u>APRIL 30, 1959</u> , and that death occurred at <u>11:58 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>307 HICKORY</u> DATE SIGNED <u>APRIL 30, 1959</u>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN</u> <u>BEL AIR, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chandler Ck/9.</u>		22d. LOCATION (City, town, or county) (State) <u>Chandler Ck/9.</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Foster</u> ADDRESS <u>West Broadway + Williams St. Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 4 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4434 CERTIFICATE OF DEATH

Reg. Dist. No. 04423

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, R.D.</u>		TOWN <u>Bel Air, R.D.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Forge Hill Rd/</u>		STREET ADDRESS (If rural give location) <u>Forge Hill Rd.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, R.D.</u>		TOWN <u>Bel Air, R.D.</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna Mae Williams</u>				4. DATE OF DEATH (Month) <u>Apr. 23</u> , (Day) <u>19</u> , (Year) <u>59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 16, 1926</u>	9. AGE last birthday <u>32</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Druescella Wilmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-28-8919</u>		17. INFORMANT & ADDRESS <u>Mrs. Emma V. Brooks, Box 242A, R.D. #1, Bel Air, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>241X Bronchial asthma</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u>, 19<u>53</u>, to <u>April 23</u>, 19<u>59</u>, that I last saw the deceased alive on <u>April 22</u>, 19<u>59</u>, and that death occurred at <u>10:40 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>April 24, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 27, 59</u>		NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel</u>		LOCATION (City, town, or county) <u>Kalmia, Harf. Co., Md.</u>	
24. REC'D BY REGISTRAR <u>APR 27 '59</u>		REGISTRAR'S SIGNATURE <u>Rollin S. Hume</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Hester</u> ADDRESS <u>W. Broadway and Williams St., Bel Air, Maryland</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4435

CERTIFICATE OF DEATH

14424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall R.D.</u>		c. LENGTH OF STAY IN 1b <u>80 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hugh Thomas Williams</u>		4. DATE OF DEATH Month Day Year <u>Apr 25 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 29 1876</u>
9. AGE (In years last birthday) yrs. <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Atmos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Jenora G Williams</u>		Address <u>White Hall Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebro-Vascular Accident.</u> DUE TO (b) <u>Arterio-Sclerosis Generalized.</u> DUE TO (c) <u>15 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1950</u> , to <u>April 25, 1959</u> , that I last saw the deceased alive on <u>April 25, 1959</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>William O. Fulton, M.D.</u> <u>4-25-59</u>			
ACTUAL SIGNATURE <u>William O. Fulton</u>			
PHYSICIAN'S NAME (Type) <u>William O. Fulton</u> <u>Stewartstown, Pa</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ayres Chapel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Morton G. Gentry, Jarrettsville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

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